ANNUAL REPORT
OF THE
INDIANA COMMISSION ON EXCELLENCE
IN HEALTH CARE

Indiana Legislative Services Agency
200 W. Washington St., Suite 301
Indianapolis, Indiana 46204-2789

November, 2004

INDIANA LEGISLATIVE COUNCIL

2004

Speaker B. Patrick Bauer
Chairman
South Bend

Senator Robert Garton
Vice-Chairman
Columbus

Representative Brian Bosma
Indianapolis

Senator Richard Young
Milltown

Representative Russell Stilwell
Boonville

Senator Becky Skillman
Bedford

Representative Dale Grubb
Covington

Senator Joseph Harrison
Attica

Representative Charlie Brown
Gary

Senator Patricia Miller
Indianapolis

Representative Scott Pelath
Michigan City

Senator Thomas Wyss
Fort Wayne

Representative Kathy Richardson
Noblesville

Senator James Lewis
Charlestown

Representative Richard Mangus
Lakeville

Senator Earline Rogers
Gary

Philip J. Sachtleben
Executive Director
Legislative Services Agency

COMMISSION ON EXCELLENCE IN HEALTH CARE

Membership Roster

Senators

Patricia Miller, Chairperson
Indianapolis

Gary Dillon
Columbia City

Allie Craycraft
Selma

Earline Rogers
Gary

Representatives

Charlie Brown
Gary

Peggy Welch
Bloomington

Vaneta Becker
Evansville

Timothy Brown
Crawfordsville

Laymembers

Beverly Richards
Fishers

Amy Brown
Indianapolis

Walter J. Daly, M.D.
Indianapolis

Michael Urban
Brazil

Greg Wilson
Indianapolis

Staff

Steve Wenning
Attorney for the Committee

Kathy Norris
Fiscal Analyst for the Committee

A copy of this report is available on the Internet. Reports, minutes, and notices are organized by committee. This report and other documents for this Committee can be accessed from the General Assembly Homepage at http://www.state.in.us/legislative/.

I. STATUTORY AND LEGISLATIVE COUNCIL DIRECTIVES

The Indiana General Assembly established the Indiana Commission on Excellence in Health Care (Commission) in 2001 under P.L. 220-2001. Various amendments were made, including topics to be studied, reporting procedures, and Subcommittee membership, under P.L. 137-2002, P.L. 1-2003, P.L. 82-2003, and P.L. 11-2004. The Commission was directed to study the quality of health care, including mental health, and develop a comprehensive statewide strategy for improving the health care delivery system. The Commission was required to do the following:

(1) Identify existing data sources that evaluate quality of health care in Indiana and collect, analyze, and evaluate this data.
(2) Establish guidelines for data sharing and coordination.
(3) Identify core sets of quality measures for standardized reporting by appropriate components of the health care continuum.
(4) Recommend a framework for quality measurement and outcome reporting.
(5) Develop quality measures that enhance and improve the ability to evaluate and improve care.
(6) Make recommendations regarding research and development needed to advance quality measurement and reporting.
(7) Evaluate regulatory issues relating to the pharmacy profession and recommend changes necessary to optimize patient safety.
(8) Facilitate open discussion of a process to ensure that comparative information on health care quality is valid, reliable, comprehensive, understandable, and widely available in the public domain.
(9) Sponsor public hearings to share information and expertise, identify best practices, and recommend methods to promote their acceptance.
(10) Evaluate current regulatory programs to determine what changes, if any, need to be made to facilitate patient safety.
(11) Review public and private health care purchasing systems to determine if there are sufficient mandates and incentives to facilitate continuous improvement in patient safety.
(12) Analyze how effective existing regulatory systems are in ensuring continuous competence and knowledge of effective safety practices.
(13) Develop a framework for organizations that license, accredit, or credential health care professionals and health care providers to more quickly and effectively identify unsafe providers and professionals and to take action necessary to remove an unsafe provider or professional from practice or operation until the professional or provider has proven safe to practice or operate.
(14) Recommend procedures for development of a curriculum on patient safety and methods of incorporating the curriculum into training, licensure, and certification requirements.
(15) Develop a framework for regulatory bodies to disseminate information on patient safety to health care professionals, health care providers, and consumers

through conferences, journal articles and editorials, newsletters, publications, and Internet websites.
(16) Recommend procedures to incorporate recognized patient safety considerations into practice guidelines and into standards related to the introduction and diffusion of new technologies, therapies, and drugs.
(17) Recommend a framework for development of community based collaborative initiatives for error reporting and analysis and implementation of patient safety improvements.
(18) Evaluate the role of advertising in promoting or adversely affecting patient safety.
(19) Evaluate and make recommendations regarding the need for licensure of additional persons who participate in the delivery of health care to Indiana residents.
(20) Evaluate the benefits and problems of the current disciplinary systems and make recommendations regarding alternatives and improvements.
(21) Study and make recommendations concerning the long term care system, including self-directed care plans and the regulation and reimbursement of public and private facilities that provide long term care.
(22) Study and make recommendations concerning increasing the number of:
(1) nurses;
(2) respiratory care practitioners;
(3) speech pathologists; and
(4) dental hygienists.
(23) Study any other topic required by the chairperson.

The Legislative Council assigned the following additional responsibilities to the Commission:

Review of data and public education programs concerning cervical, prostate, and breast cancer and options for improving screening accuracy. (Legislative Council Resolution 04-01)

School nutrition. (Legislative Council Resolution 03-01)

Stroke prevention. (Legislative Council Resolution 03-01)

Home health care. (Legislative Council Resolution 03-01)

Small pox immunizations. (Legislative Council Resolution 03-01)
Self-directed care and expansion of personal care services. (Legislative Council Resolution 02-01)

Reduction in the number of birth defects. (Legislative Council Resolution 02-01)

Improving cancer outcomes; health care coverage of costs related to oncology clinical trials. (Legislative Council Resolution 02-01)

II. SUMMARY OF WORK PROGRAM

In 2001, the Commission established a three year work plan and created the following Subcommittees to study specific topics and to report to the Commission:

- Health Care Data & Quality Subcommittee
- Health Care Professions Subcommittee
- Patient Safety Subcommittee
- Long Term Care Subcommittee

During the 2002 interim, the Commission reviewed the process, framework, and progress of each Subcommittee. The Commission also heard reports on the following:

- The incidence and treatment of strokes in Indiana.
- The purpose, status, and collection of cancer registry data.

The Commission met five times during the 2003 interim and received work in progress updates from the four Subcommittees. The Health Care Professions Subcommittee issued their final report in October of 2003. (Exhibit #1) The Commission also received testimony on the following topics:

- Stroke prevention and treatment.
- School nutrition and childhood obesity.
- Small pox immunization.

The Commission issued Interim Reports in 2001, 2002, and 2003.

In 2004, the Commission met three times as follows:

August 16th - State House, Indianapolis. The Commission received final Subcommittee reports and heard testimony on the immunization registry system, orientation classes for new health profession board members, and public education programs and data concerning cervical, prostate, and breast cancer and options for improving screening accuracy.

September 30th - State House, Indianapolis. The Commission heard presentations on office-based sedation standards, childhood obesity, cultural competency, and management of complaints against physicians.

October 27th - State House, Indianapolis. The Commission heard presentations on

bariatric surgery, patient safety and quality initiatives, integrated health care data systems, and health care quality indicator data programs. The Commission also adopted findings and recommendations for the Commission's final report.

III. SUMMARY OF TESTIMONY

During the 2004 interim, the Commission received final reports from the following Subcommittees:

The **Patient Safety Subcommittee** issued findings and recommendations (Exhibit #2) in the following three patient safety areas:

- The administration of office based anesthesia. The annual number of procedures performed in ambulatory surgical centers has increased 220% in the last decade. The exact number of procedures performed in physicians' offices is not known in Indiana and many other states because of a lack of state regulation or oversight.
- The Subcommittee recommended that the Medical Licensing Board of Indiana (Board) adopt rules concerning minimum standards for in-office procedures that require certain types of sedation or anesthesia.
- The State's management of patient safety complaints and other reports about patient safety. Reports indicate that medical errors reduce patient safety. The Subcommittee concluded that reforms to the medical licensure and disciplinary authority could reduce errors. The Subcommittee's recommendations included:
- Consolidate investigation and enforcement of patient and other complaints against physicians.
- Streamline adjudication of complaints with increased use of administrative law judges.
- Streamline evidentiary rules in the adjudication of complaints.
- Establish a voluntary education, training, and supervision program for physicians with problems with patient safety.
- Amend the medical licensing law to conform to the Federation of State Medical Boards Model State Practice Act (e.g. allow the Board to receive, review, and investigate complaints at all stages, establish budgets, and retain medical licensing fees in an account to operate the Board's activities.)
- The regulatory programs concerning the provision of attendant care services. The Indiana State Department of Health and the Family and Social Services Administration are currently finalizing a Memorandum of Understanding to coordinate these efforts.

The **Long Term Care Subcommittee** identified the following barriers to Indiana's long term care system in their final report (Exhibit #3):

- Financial eligibility standards for the federal Aged and Disabled Waiver, Assisted Living Waiver, and Traumatic Brain Injury Waiver.
- Lack of spousal impoverishment protection for all Medicaid Waivers.
- Money currently does not follow the person receiving Medicaid services.
- The lack of incentives for people to use their own funds in the long term care system.
- The lack of an informal unpaid care giver program.
- The current system does not provide a full array of long term care services.
- The state's nursing facilities have an occupancy rate of 75% compared to a national average of 90% occupancy.
- The state long term care infrastructure needs to be reinforced.

The Subcommittee noted that legislation has passed over the last couple years to address several of these problems. However, some legislation (e.g. SEA 493-2003) has not been fully implemented. The Health Finance Commission examined issues related to the implementation of SEA 493-2003 during the 2004 interim.

The **Health Care Data and Quality Subcommittee** noted that nationally there has been significant movement in recent years to improve health care quality. The Subcommittee decided to narrow the focus of the recommendations in its final report (Exhibit #4) to the most important areas to improve health care in Indiana. The Subcommittee made three recommendations in the following areas:

- Preventive care measures. Institute a complete immunization registry that would initially focus on childhood immunizations.
- Disease management registry for chronic illnesses. Begin the registry with diabetes and asthma which already have clearly defined approaches to optimal medical care.
- Hospital quality reporting. Begin with 5-10 quality control measures, with initial measurements focusing on cardiac care and pneumonia care.

The Commission also heard testimony on the following topics:

Immunization Registry System

Indiana currently has a voluntary immunization registry system for the Medicaid program. This system has improved Indiana's immunization rates. The system should be expanded to receive information from the private sector of the health care system. A good immunization registry includes an integrated network to receive and share data.

- Greg Wilson, M.D., Commissioner, Indiana State Department of Health (ISDH)

New Health Profession Board Orientation

Based on previous recommendations made by the Health Care Professions Subcommittee, a

manual entitled "New Health Profession Board Member Manual" has been created. This manual, along with a PowerPoint presentation, will be used in an orientation class for all new health profession board members.

- Beverly Richards, Chairperson, Health Care Professions Subcommittee

Cervical, Breast, and Prostate Cancer Education and Screening

Indiana has taken positive steps to make women aware of the risks and treatments regarding cervical cancer. Cervical cancer used to be the number one cancer killer of women. It has now dropped to the number 13 cancer killer of women. Cervical cancer is curable if detected in its early stages. Certain risk factors increase the chance of developing cervical cancer (e.g. human papillomavirus infection, smoking, obesity).

- Senator Connie Lawson, State Senator, District 24

The Indiana Cancer Consortium (ICC) is comprised of 110 public and private organizations. The ICC has eight priority areas (including prostate and cervical cancer) and has advisory panels for each area. The advisory panels released their goals and objectives (e.g. prevention, screening, and treatment) on October 20, 2004.

- Michael Wade, Cancer Control Manager, American Cancer Society

Cervical cancer should be almost preventable. However, there are ethnic and racial issues that do not assure access. Hispanics have a higher rate of cervical cancer than the black population. Caucasians have the state's lowest rate. Many women have access to health care services during child-bearing years but the number of uninsured and underinsured women rises later in life. Many Hispanic women who are screened cannot get follow-up care due to citizenship issues. The American Cancer Society no longer has a goal for annual testing by all women but rather increased targeted testing based on the woman's risk level and past test results. There is a new cervical cancer test that is capable of detecting precancerous cells. However, the cost of the test is about 2-3 times the cost of the current test procedure.

- Marilyn Graham, M.D., Associate Professor, Clinical Obstetrics and Gynecology, Indiana University School of Medicine

The incidence of breast cancer in Indiana is lower than the national average. However, the mortality rate for breast cancer in the state is higher than the national average. Experts do not know why this is so. The Caucasian, African-American, and Hispanic population groups are all screened at a rate of about 55% annually. However, the mortality rate among African-Americans is much higher. About 92% of all women have had at least one mammogram in their lifetime. Although the incidence of breast cancer increases with age, older women have a lower rate of screening. Most women seek screening based on the recommendation of their health care provider. The public and physicians need more education on the breast cancer risk status of women.

- Victoria Champion, DNS, RN, FAAN, Director of Cancer Control, Indiana University

Cancer Center

Each year in Indiana 5,000 men will be diagnosed with prostate cancer and about 700 men will die. The leading risk factors for prostate cancer are family history and age. African-Americans have about twice the rate of prostate cancer as other population groups. Current treatment options include radiation and surgery. Information obtained from autopsies indicates that about 75% of all men in their 80's have prostate cancer although many of these men did not experience any prostate related problems before they died. The prostate specific antigen (PSA) test is used to detect prostate cancer. Unfortunately, the PSA test gives many false positive and false negative results. Testing is not suggested for people who have a life expectancy of less than 10 years.

- Steven D. Williams, M.D., Director, Indiana University Cancer Center

The Office of Women's Health is using a new pamphlet to educate women about the human papillomavirus (HPV) infection's link to cancer, how HPV can be diagnosed, and information on prevention.

- Barb Levy Tobey, Director, Office of Women's Health, Indiana State Department of Health

The Indiana Breast and Cervical Cancer Program is funded from the federal Cancer Control Grant. Money is used for cancer screening. Women with low incomes and lower educational levels are targeted to be screened. The state divides the program into different geographical areas with a manager assigned to each area.

- Zach Cattell, Legislative Liaison, Indiana State Department of Health

Office-based Sedation Standards

There has been a huge increase in the use of in-office sedation for various procedures. Several states have reported patient deaths in plastic surgery procedures. The current rules governing sedation standards do not fit with modern practice. Many states have not regulated office-based sedation standards until they have encountered a problem. Currently, eighteen states regulate office-based sedation.

- Libby Cierzniak, Member, Patient Safety Subcommittee, Baker & Daniels

Some physicians who have little or no training or experience in sedation are working with anesthesia in an office-based setting. Sedation is part of a continuum. A patient can slip between stages of sedation (e.g. light to deep sedation) easily. Patients in deeper levels of sedation face additional risks. However, these risks can be managed. In the office setting it is particularly important to be well trained since this setting does not have the emergency backup that is found in hospitals or outpatient surgery centers There are already standards for hospitals and outpatient centers - physician offices that use sedation should provide a similar level of safety.

- Don Stogsdill, M.D., President, Indiana Society of Anesthesiologists

Advanced technology allows more procedures to be performed in outpatient settings. Giving the Medical Licensing Board the authority to regulate this area allows them to modify the standards as medical technology changes.

- Mike O'Brien, Indiana State Medical Association (ISMA)

Dentists and better equipped facilities (i.e. hospitals and outpatient centers) have regulations concerning sedation but the use of anesthesia in an office-based setting is not regulated. A patient is entitled to quality care regardless of the setting in which the sedation is administered.

- Robert Brandt, M.D., Member, Patient Safety Subcommittee, Past President, Indiana Society of Anesthesiologists

Certified Registered Nurse Anesthetists (CRNAs) have guidelines and checklists for the safe use of sedation and anesthesia in office-based settings. A patient under deep sedation needs a trained person whose only responsibility is to monitor the patient and take care of any sedation problems that may arise.

- Jackie Rowles, CRNA, Past President, Indiana Association of Nurse Anesthetists

Registered Nurses, who are not CRNA's, are administering certain anesthesia without proper supervision or training. A person who administers anesthesia should not be the same person who provides the underlying procedure.

- Cornelia Hammerly, CRNA, President, Indiana Association of Nurse Anesthetists

Childhood Obesity

The Indiana State Department of Health has developed a long term plan to reverse the escalating trend in obesity. The plan focuses on prevention and includes the following components:

- Create an awareness of the problem, including early family education.
- Promote opportunities to change.
- Encourage appropriate legislation.
- Measure the trend of growth in children to identify overweight problems early.
- Coordinate prevention efforts between the government, business, education, and medical communities.

Obesity in children is a societal problem that will take 2-3 generations to correct.

- Bill Wishner, M.D., Indianapolis

Support for legislation to combat obesity has grown over the past three years. Society is starting to react but the problem has continued to get worse. Fast food restaurants are beginning to offer better choices, some schools are limiting access to vending machines, and employers are offering fitness incentives. Obesity increases health care costs and is a leading cause of death. Trying to offer healthy choices in school vending machines has met resistance. Vendors want to sell their products and schools like the revenue. Activity programs in schools should be another focus. Studies indicate that physical activity and healthy students actually improve test scores and

increase the attention of students in the classroom.

- Mike O'Brien, Indiana State Medical Association (ISMA)

Schools need healthy whole foods in the school environment. Overweight children generally are absent from school at a higher rate than other children, experience higher health care costs, and do not perform as well in school. Physical activity is linked to increased attention and test scores. A child's nutritional choices in school should be from healthy options. Taxpayers should not have to accept the growing burden related to poor nutrition.

- Lisa Woods, Indiana Dietetic Association

The Boys and Girls Clubs have programs that address youth obesity by offering healthy lifestyle activities. A successful program actively changes the child's lifestyle. 97% of the children in the programs self report that the Clubs help them implement a healthy lifestyle and habits.

- Mark Branch, Boys and Girls Club of Indianapolis

Boys and Girls Clubs offer after school activities and are in a unique position to address the problem of obesity and healthy lifestyle. Children have many indoor options to occupy their time (e.g. video games, television, junk food, etc.). The Clubs have for years run physical fitness programs and other programs that address obesity and healthy lifestyle.

- Chuck Leer, President, Porter County Boys and Girls Club

Westfield Intermediate School has created a "Walk Across America" program for the school's 5th and 6th graders. The program was developed to focus on the prevention of obesity through more physical activity outside of physical education classes and sports. Students log the number of steps they take each day. Log sheets are collected and the information is tracked on an individual, classroom, and student body basis. The number of miles that they walk is tracked on huge map of the United States and progress is updated on the map each week. The program is also looking at students who are not participating and trying to address how to get them involved.

- Susie Borgnini and Kelly Brown, RN, Westfield Intermediate School

Cultural Competency

Cultural competency in health care is the development and maintenance of interpersonal and professional skills to increase one's respect for, understanding of, and knowledge of the differences between patient and practitioner values, lifestyles, norms, beliefs, and opportunities that influence every aspect of the health care delivery system. Cultural competency is not the same as linguistic competency. Studies have shown physicians prescribing different treatment to patients based on the patient's race or gender.The Indiana State Department of Health created the Office of Cultural Diversity and Enrichment in 2001 to help address public health needs of minorities.

Future recommendations include the following:

- Create a cultural competency curriculum that health care professionals would receive in school and at hospitals.
- Require cultural competency as part of continuing education for regulated health care professionals.
- Require that health service organizations use a formal mechanism for community and consumer involvement.
- Create a licensure process to ensure that interpreters are proficient.
- Ensure a patient's primary spoken language and self-identified race/ethnicity are included on the patient's records.
- Increase the proportion of under represented minorities among health care professionals.

- Calvin Roberson, MPH, MHA, Research Director, Indiana Minority Health Coalition

The ISDH Office of Cultural Diversity and Enrichment is providing cultural training. The class was developed to address problems that ISDH employees and contractors may have in interacting with minorities. The initial class focuses on African-Americans, Asians, and Native Americans. A second class is available that includes other cultures.

- Zach Cattell, Legislative Liaison, Indiana State Department of Health (ISDH)

Management of Complaints Against Physicians

Recommended changes to the physician disciplinary system are in response to the frustration that patients and physicians have with the current process. The existing system takes a long time to either discipline or clear an accused physician. The Patient Safety Subcommittee used the Model Medical Practice Act (MMP Act) prepared by the Federation of State Medical Boards as the template for reform.

- Ken Stall, M.D., Member, Patient Safety Subcommittee/Indiana State Medical Association

The Attorney General's (AG) Office supports much of the Patient Safety Subcommittee's report (e.g. increase the use of administrative law judges, amend the standards for disciplinary actions, and create better tools to discipline physicians). However, the Office does not support the consolidation of investigation and prosecution of complaints in the Medical Licensing Board (Board). Merging these functions would mean the Board would lose the ability have an independent review of the complaints.

- Jennifer Thuma, Legislative Counsel, Office of the Attorney General

The Health Professions Bureau (HPB) works with 24 different boards and over 40 different types of licenses. The recommendation by the Patient Safety Subcommittee is targeted solely at the Medical Licensing Board. Under this proposal the HPB and the AG's Office would have to work under a bifurcated system. Administrative law judges (ALJs) are already being used for hearings. The suggestion that a pool of ALJ's be created and that ALJ's decisions be final would work if

additional funding and training is available. The investigation of a complaint is usually the part of the process that takes the most time. Also, IC 16-21-2-6 needs to be amended to prompt hospitals to report disciplinary actions taken against physicians.

- Barbara McNutt, General Counsel, Health Professions Bureau (HPB)

Bariatric Surgery

In 1997, Indiana became one of three states that had an adult obesity level of 20% or greater. A study of the prevalence of overweight and obesity in select groups demonstrates that there are ethnic and racial disparities. Surgical procedures have emerged as treatment for the severely obese. Anthem's medical policy on bariatric surgery covers gastric bypass for severely obese adults who have failed conservative therapy. Patients under the age of 18 are evaluated on case by case basis. In 2002, Anthem had 4707 admissions for bariatric surgery (686 in Indiana). Total cost per surgery (including facility, professional, and ancillary costs) can be as much as $16,000. About 20% of bariatric surgery patients are eventually rehospitalized - with 14% being rehospitalized within 30 days of having bariatric surgery.

- Randy L. Howard, M.D., Senior Medical Director, Anthem Blue Cross Blue Shield

Bariatric surgery requires a comprehensive program with ancillary services. Bariatric surgery should not be performed on a child. Each bariatric surgery candidate is assessed by a multidisciplinary group and evaluated on a weekly basis to determine if they would be a good candidate for bariatric surgery. There is a risk of complications and mortality but the benefits outweigh the risks. Patients should understand what the risks are and what to expect after surgery. As people gain weight it becomes harder to loose weight. Once a person is above a 55 body mass index (BMI) it is virtually impossible to loss weight through dieting.

- Charles Stone, M.D., Surgeon, Goshen, Indiana

Patient Safety and Quality Proposal

The Indiana Association for Healthcare Quality has prepared a Patient Safety & Quality Initiative Proposal to advance collaboration in Indiana regarding dissemination of clinical practices in order to promote the enhancement of patient safety and quality care. Health care facilities are expected to meet requirements for improving processes and reporting outcomes but there is very little support to assist the facilities in meeting these demands. When each facility has to develop the policies, procedures, and forms to implement a clinical best practice valuable time and resources are wasted. Having a central database with this information available to all providers saves time and health care dollars.

-Linda Ostermeier, RN, St. Francis Hospital, Indiana Association for Healthcare Quality

Integrated Health Care Data Systems

Various reports have documented the problems of medical errors. Putting technology to work can reduce costs and cut the error rate in hospitals. A hospital in Utah has reduced its error rate by 90% after implementing an in-house computer system. Health care professionals should have the best health care information available whenever it is needed. Nobody can keep track of the drugs and proper dosages that are available on the market. Health care systems technology can assist with proper dosage information. Most of this information is currently available. The state should be involved in order to help create a statewide system. The federal government wants to see health care systems technology created, so there is a possibility that the state could receive federal money to continue to develop the system.

-Senator Gary Dillon, M.D., State Senator, District 17

Indiana is poised to be a national leader in integrated health care data systems. Indiana is close to having a statewide integrated data system available through a joint public and private initiative. The Indiana Health Information Exchange (IHIE) is considered the private sector leader. Many different groups are interested in this system being developed because of the potential for better health outcomes and lower costs. An integrated health care data system can help physicians with chronic disease management (e.g. currently only 30% of diabetics receive the recommended annual tests and procedures). The bioterrorism surveillance network already provides pharmacy data.

- Gregory Wilson, M.D., Commissioner, Indiana State Department of Health

The current health care system is fragmented. Most people see multiple health care providers every year. As the population ages patients have more chronic conditions. According to the New England Journal of Medicine only half of the patients receive appropriate follow-up care. A paperless health care system is not the objective. Most health care organizations invest very little in information technology (i.e. 2.2% of their annual spending), which is well below what other industries invest in data development. An integrated health care data system is a regional database in which the information that is placed in the system is controlled by the patient and the health care provider. The system includes privacy safeguards. The system would collect health information from all health care providers, and would include prescription information, lab results, and radiologic images. The system will help reduce unnecessary medical expenses and provide better management of care to patients. It is estimated that the health care savings in Central Indiana would be about $120 million annually.

- Dr. J. Marc Overhage, Indiana Health Information Exchange

Health Care Quality Indicator Data Program

SB 482-2004 was introduced to require the Indiana State Department of Health to develop a health care quality data program with data that has already been collected. The idea is to "glean existing information to improve health care.

- Senator Gary Dillon, M.D., State Senator, District 17

Valid health indicators need to be established to provide consistent health care outcomes. It is difficult to collect a standard and uniform medical record. The issue of who controls the data involves a proprietary issue. Public health needs to have aggregated data instead of individual level data. With better public health data there is a savings potential.

- Gregory Wilson, M.D., Commissioner, Indiana State Department of Health

IV. COMMITTEE FINDINGS AND RECOMMENDATIONS

The Commission made the following findings of fact:

- That to improve Indiana public health the Indiana State Department of Health should develop and implement a health care quality indicator data program.

- That investigations against physicians take too long to complete and that efforts need to be made to change the investigation system to expedite the investigation of complaints.

The Commission made the following legislative recommendations during the 2004 interim:

-Require school corporations through 2015 to report student growth information to the Indiana State Department of Health in a manner that does not make students personally identifiable. (PD 3401, as amended)

- Require the Medical Licensing Board to adopt rules concerning office based procedures that require certain levels of sedation. (PD 3194)

The Commission made the following legislative recommendations during the 2003 interim:

- Establish the Stroke Prevention Task Force to develop stroke prevention initiatives and prepare an annual report. (PD 3307-2003)

- Require the Indiana Department of Education to develop: (1) recommendations for school corporation nutritional policies and curricula; and (2) model policies for the measurement of student body mass indexes. Require school corporations to adopt nutritional integrity policies. (PDoc 20041458.001-2003)

- Require physical activity during the school day at least five days each week for students in public schools. (PD 3357-2003)

W I T N E S S L I S T FOR 2004

Stephen L. Albrecht	Long Term Care Subcommittee
Susie Borgnini	Westfield Intermediate School
Mark Branch	Boys and Girls Club of Indianapolis
Robert Brandt, M.D.	Patient Safety Subcommittee/Indiana Society of Anesthesiologists
Kelly Brown, RN	Westfield Intermediate School
Zach Cattell	Indiana State Department of Health
Victoria Champion, DNS	Indiana University Cancer Center
Libby Cierzniak	Patient Safety Subcommittee/Baker & Daniels
Senator Gary Dillon, M.D.	Indiana Senate District 17
Marilyn Graham, M.D.	Indiana University School of Medicine
Cornelia Hammerly, CRNA	Indiana Association of Nurse Anesthetists
Randy L. Howard, M.D.	Senior Medical Director, Anthem Blue Cross Blue Shield
Eleanor Kinney, J.D., MPH	Patient Safety Subcommittee
Senator Connie Lawson	Indiana Senate District 24
Chuck Leer	Porter County Boys and Girls Club
Barbara McNutt	Health Professions Bureau
Sam Nussbaum, M.D.	Health Care Data and Quality Subcommittee
Mike O'Brien	Indiana State Medical Association
Linda Ostermeier, RN	St. Francis Hospital, Indiana Association for Healthcare Quality
Dr. J. Marc Overhage	Indiana Health Information Exchange
Beverly Richards, DSN, RN	Health Care Professions Subcommittee
Calvin Roberson, MPH, MHA	Indiana Minority Health Coalition
Jackie Rowles, CRNA	Indiana Association of Nurse Anesthetists
Mark Scherer	Beebe, Scherer and Associates
Ken Stall, M.D.	Patient Safety Subcommittee/Indiana State Medical Association
Don Stogsdill, M.D.	Indiana Society of Anesthesiologists
Charles Stone, M.D.	Surgeon, Goshen, Indiana
Ralph Stuart, M.D.	Physician
Jennifer Thuma	Office of the Attorney General
Barb Levy Tobey	Office of Women's Health, Indiana State Department of Health
Michael Wade	American Cancer Society
Steven D. Williams, M.D.	Indiana University Cancer Center
Greg Wilson, M.D.	Indiana State Department of Health
Bill Wishner, M.D.	Indianapolis
Lisa Woods	Indiana Dietetic Association

WITNESS LIST FOR 2003

Elizabeth Hamilton Byrd, M.D.	Indiana State Department of Health
Zach Cattell	Indiana State Department of Health
Judy Chin, D.D.S	Indiana School of Dentistry
Jennifer Cohn, RN	Clarian Health
Suzanne Crouch	Indiana Department of Education
Danielle DelCarlo	National Automatic Merchandising Association
Sara Gasiorowski	Indiana School Food Service Association
Tamara Hannon, M.D.	Indiana School of Medicine
Charlie Hiltunen	American Heart Association
Peggy Huffman	Parent
Paul Mannweiler	Indiana Soft Drink Association
Debra Miller-Carter, M.D.	Mapleton Medical Center
Douglas Morrell, M.D.	Rush County School Board Member
Representative Cindy Noe	Indiana House of Representatives District 87
Michael O'Brien	Indiana State Medical Association
Nancy Perry	Indiana Vending Council
Jerry Pochler	Avon Vending
Greg Poe	American Heart Association/Operation Stroke
Martha Rardin	Indiana Dietitic Association
Patricia Richards	American Cancer Association
Dr. Bob Rider	Coordinated School Health Advisory Council/College of Education, Butler University
Greg Wilson, M.D.	Indiana State Department of Health

WITNESS LIST FOR 2002

Jennifer Cohn, RN	Clarian Health/Operation Stroke
Kim Dodson	Long Term Care Subcommittee/The ARC of Indiana
Melissa Durr	Long Term Care Subcommittee/Indiana Association of Area Agencies on Aging
Jim Jones	Health Care Professions Subcommittee
Eleanor Kinney, J.D., MPH	Patient Safety Subcommittee
Ernest Klein, Jr.	Patient Safety Subcommittee
Dr. Anna Miller	Great Lakes Division of the American Cancer Society
Sam Nussbaum, M.D.	Health Care Data and Quality Subcommittee
Beverly Richards, DSN, RN	Health Care Professions Subcommittee

WITNESS LIST FOR 2001

Kim Dodson	Long Term Care Subcommittee
Ernest Klein, Jr.	Patient Safety Subcommittee
Sam Nussbaum, M.D.	Health Care Data and Quality Subcommittee
Beverly Richards, DSN, RN	Health Care Professions Subcommittee